MEDICARE APPEALS AND QUALITY OF CARE GRIEVANCES
XYZ Organization
April 1, 1999 to September 30, 1999

What kind of information is this?

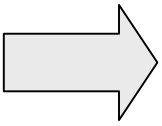
When you ask for it, the government requires XYZ Organization to provide you with reports that describe **what happened** to formal complaints that XYZ Organization received from their Medicare members. There are two types of formal complaints: **appeals and grievances. Medicare members have the right to file an appeal or grievance with their Medicare health plans**. The next few pages contain information about the appeals and quality of care grievances that XYZ Organization received between April 1, 1999 and September 30, 1999.

Each Medicare health plan will have different numbers of appeals and quality of care grievances, and these numbers can mean different things. For example, a Medicare health plan might have a small number of appeals and quality of care grievances because the plan talks with members about their concerns and agrees to find solutions. Or a Medicare health plan might have a small number of appeals and quality of care grievances because its members are not aware of their right to file an appeal or grievance.

How big is XYZ Organization?

XYZ Organization has about **88,000** Medicare members.
(line 3 on the attached report)

- Appeals Information beginning on Page 2
- Quality of Care Grievance Information on Page 6



INFORMATION ON MEDICARE APPEALS

April 1, 1999 to September 30, 1999

What is an appeal?

An appeal is a formal complaint about XYZ Organization's decision not to pay for, not to provide, or to stop an item or service that a Medicare member believes s/he needs.

If a member cannot get an item or service that the member feels s/he needs, or if the health plan has denied payment of a claim for a service the member has already received, the member can appeal. For example, a member might appeal XYZ Organization's decision to stop physical therapy, to deny a visit to a specialist, or to deny payment of a claim.

How many appeals did XYZ Organization receive?

XYZ Organization received **174** appeals from its Medicare members. About **2 out of every 1,000** Medicare members appealed XYZ Organization's decision not to pay for or provide, or to stop a service that they believed they needed. (lines 2 and 4 on the attached report)

How many appeals did XYZ Organization review?

XYZ Organization reviewed **157** appeals during this time period. (lines 5 through 8 on the attached report)

What happened?

From the **174** appeals it received from its members:

XYZ Organization decided to pay for or to provide all services that the member asked for **41%** of the time.

XYZ Organization decided not to pay for or to provide the services that the member asked for **49%** of the time.

Medicare members withdrew their request before XYZ Organization could decide **10%** of the time.

Expedited or "Fast" Appeals Information on Page 3

INFORMATION ON EXPEDITED OR "FAST" APPEALS

April 1, 1999 to September 30, 1999

What is a "fast" or expedited appeal?

A Medicare member can request that XYZ Organization review the member's appeal quickly if the member believes that his health could be seriously harmed by waiting for a decision about a service. This is called a request for an **expedited** or **"fast" appeal.**

XYZ Organization looks at each request and decides whether a "fast" appeal is necessary. By law, XYZ Organization must consider an appeal as quickly as a member's health requires. If XYZ Organization determines that a "fast" appeal is necessary, it must notify the Medicare member as quickly as the member's health requires but no later than 72 hours.

How many "fast" appeals did XYZ Organization receive?

XYZ Organization received **20** requests for "fast" appeal from its Medicare members. (lines 14 through 16 on the attached report)

What happened?

When a member requested a "fast" review, XYZ Organization agreed that a "fast" review was needed **75%** of the time.

XYZ Organization did not agree to a "fast" review **25%** of the time. This number may include requests by members for whom the health plan may not have believed were in danger or serious harm.

Independent Review of Appeals on Page 4

INFORMATION ON INDEPENDENT REVIEW

April 1, 1999 to September 30, 1999

What is Independent Review of an appeal?

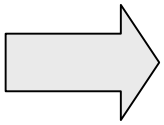
After a member has sent an appeal to XYZ Organization, if the organization continues to decide that it should not pay for or provide all services that the member asked for, XYZ Organization must send all of the information about the appeal to an **independent review organization** that contracts with Medicare, not for XYZ Organization.

An independent review provides an opportunity for a new, fresh look at the appeal outside of the health plan. The independent review organization goes over all of the information from XYZ Organization and can consider any new information.

If the independent review organization does not agree with XYZ Organization's decision, XYZ Organization must provide or pay for the services that the Medicare member requested.

There may be several reasons why the independent review organization decides to agree with either the Medicare member or XYZ Organization. For example, the independent review organization may disagree with XYZ Organization because the independent review organization may have had more information about the appeal.

Independent Review Continued on Page 5



INFORMATION ON INDEPENDENT REVIEW

April 1, 1999 to September 30, 1999

How many appeals did the independent review organization consider?

The independent review organization considered **86** appeals from XYZ Organization. (lines 9 through 13 on the attached report)

What happened?

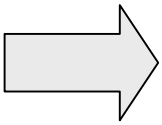
The independent review organization agreed with the Medicare member's appeal **19%** of the time. This means that in **19%** of these cases, XYZ Organization ended up paying for or providing all services that these members asked for.

The independent review organization disagreed with the Medicare member's appeal **70%** of the time. This means that in **70%** of these cases, XYZ Organization ended up not paying for or providing all services that these members asked for.

Medicare members withdrew their request for independent review **9%** of the time.

By September 30, 1999, **2%** of appeals were still waiting to be reviewed by the independent review organization.

Note that these percentages may not add to 100% because sometimes the independent review organization dismisses an appeal.



INFORMATION ON QUALITY OF CARE GRIEVANCES

April 1, 1999 to September 30, 1999

What is a quality of care grievance?

A grievance is a complaint that a Medicare member makes about the way XYZ Organization provides care (other than complaints about requests for service or payment). A **grievance** about the **quality of care** is one kind of grievance. For example, a member can file a grievance about the quality of care when the member believes that the service the member received was not timely or correct, when the member had problems getting a service because of long waiting times or long travel distances, or when the wrong kind of doctor or hospital provided the service.

How many quality of care grievances did XYZ Organization receive?

XYZ Organization received **20** grievances about the quality of care. About **less than 1 out of every 1,000** Medicare members filed a grievance about the quality of care they received from XYZ Organization doctors and hospitals. (lines 2 and 4 under "Quality of Care Grievance Data" on the attached report)

Where can I get more information?

If you are a member of XYZ Organization, you have the right to file an appeal or grievance.

You can contact XYZ Organization at (###) ###-#### to resolve a concern you may have or to get more information on how to file an appeal or grievance. (Be sure to include a phone number for the hearing impaired and your hours of operation.) You may also refer to your Evidence of Coverage for a complete explanation of your rights.

You also can contact a group of independent doctors in STATE, called a Peer Review Organization, at (###) ###-#### for more information about quality of care grievances or to file a quality of care grievance.